APPLICATION

For Questions: Call 1-888-680-7342 ext. 207

Mail to: AccessWV, c/o PEIA
Capitol Complex, Building 5, Room 1001
Charleston, West Virginia 25305-0710

1. Applicant Information

Last Name_____ First Name_____ MI___ Birth Date (MM/DD/YY) _____ Age ____

Street Address _____ City_____ County_____ State WV Zip_____

Soc. Sec. #_____ Gender ☐ Male ☐ Female

Home Phone _____ Work Phone _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Bill to (Name) *if different than applicant* _____ Relationship to Applicant _____

Billing Address (if different than residence)_____ City_____ State ___ Zip _____

2. Residence

Are you a resident of West Virginia? ☐ Yes ☐ No

Have you been a resident of West Virginia for at least the last 30 days? ☐ Yes ☐ No

3. Eligibility for Public Programs

Have you applied for or are you enrolled in: Medicare? ☐ Yes ☐ No

Medicaid? ☐ Yes ☐ No

WV CHIP? ☐ Yes ☐ No

If "yes", please explain _____

Do you receive Social Security Disability? ☐ Yes ☐ No

4. Previous Insurance

Date of Last Health Insurance Coverage _____ Name of Last Insurance Company _____

Reason Coverage Ended _____

Are you eligible for but NOT enrolled in COBRA? ☐ Yes ☐ No

Have you ever been enrolled in AccessWV? ☐ Yes ☐ No

If "yes", last date of coverage _____

5. Eligibility Category and Documentation

Please check your basis for eligibility in AccessWV.

☐ **Federally Qualified Eligible Individual through HIPAA**

Please attach:

(1) copy of letter from insurer or employer indicating COBRA coverage has been exhausted or that no COBRA is available **AND**

(2) copy of Certificate of Group Health Insurance Coverage***.***

☐ **Person Eligible for the Health Coverage Tax Credit**

Please attach:

(1) copy of IRS letter indicating eligibility for HCTC **AND**

(2) copy of letter from employer or insurance carrier, indicating coverage period and last day of coverage.

☐ **Medically Eligible Person**

Please check the box that describes your situation:

☐ I was denied health insurance due to health reasons. ***Attach copy of denial letter from insurance company dated within the last 6 months.***

☐ I was offered health insurance but it restricted or denied coverage for a medical condition. ***Attach a copy of the letter from the insurance company dated within the last 6 months.***

☐ I was offered health insurance, but the premium was higher than AccessWV's premium for similar coverage. ***Attach a copy of the letter from the insurance company dated within the last 6 months.***

☐ I have been diagnosed with, or treated for, a medical or health condition that appears on the list of conditions for which a person is eligible for coverage in AccessWV without applying for health insurance. Please check below.

Qualified Health Conditions

Cardiovascular
- ☐ Aneurysm
- ☐ Angioplasty
- ☐ Bypass Surgery
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Heart Valve Replacement
- ☐ Pacemaker Implant
- ☐ Thrombophlebitis
- ☐ Valvular Disease

Endocrine/Exocrine System
- ☐ Diabetes

Gastrointestinal
- ☐ Cirrhosis of the Liver
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Hepatitis C

Immunological
- ☐ AIDS
- ☐ AIDS Related Complex
- ☐ HIV Positive Status
- ☐ Rheumatoid Arthritis
- ☐ Systemic Lupus

Kidney
- ☐ Dialysis
- ☐ Renal Failure

Musculoskeletal
- ☐ Herniated/Degenerative Disc
- ☐ Joint Replacement
- ☐ Marfan's Syndrome
- ☐ Muscular Dystrophy
- ☐ Spina Bifida Occua
- ☐ Spinal Disorders

Neurological
- ☐ Alzheimer's Disease
- ☐ Cerebral Palsy
- ☐ Down's Syndrome
- ☐ Parkinson's Disease
- ☐ Stroke
- ☐ Myasthenia Gravis
- ☐ Multiple Sclerosis
- ☐ Paralysis

Psychiatric
- ☐ Psychosis
- ☐ Attempted Suicide

Pulmonary
- ☐ COPD
- ☐ Cystic Fibrosis
- ☐ Emphysema

Other
- ☐ Hemophilia
- ☐ Infertility Treated with Medications
- ☐ Infertility: In Vitro or GIFT
- ☐ Pregnancy
- ☐ All cancerous conditions within the first five years except Basal Cell (skin) Cancer
- ☐ Applicant has been advised to have surgery that has not yet been performed. Please indicate the reason for the surgery and if it is scheduled, and for what date.

Surgery for:

_____

_____

Surgery date: _____

6. Other Eligibility Information

Employment ***(If applicant is a child, please provide information for the parents' employers.)***

Are you? ☐ an employee ☐ self-employed ☐ not employed ☐ retired

Employer _____
Name Street Address City State

Does your employer offer health insurance to its employees? ☐ Yes ☐ No

If "yes", why are you not covered? _____

Spouse's employer _____
Name Street Address City State

Does your spouse's employer offer dependent health insurance coverage? ☐ Yes ☐ No

If "yes", why are you not covered?_____

7. Statistical Information

What is your total annual gross household income? Gross income is your income before taxes and any other deductions. ☐ **$0- $19,999** ☐ **$20,000- $39,999** ☐ **$40,000- $59,000** ☐ **$60,000+**

What is your current household size? Include your spouse and all dependents living in your household whether or not they may be covered by AccessWV. _____ persons in household
Number

8. Plan You Wish to Select

☐ Plan A ☐ Plan B ☐ Plan C

9. Kind of Coverage

☐ Single Coverage ☐ Family Coverage ***(Complete "Dependent Information" below.)***

Dependent Information

	Last Name First Name MI	Gender	Birth date	Soc. Sec. #
Spouse				
Child				
Child				
Child				
Child				

Are any of the listed dependents eligible for Medicare, Medicaid or WV CHIP? ☐ Yes ☐ No

If "yes" provide details_____

10. Premium Payment

For your coverage to become effective, you must submit the first month's premium with your application and make arrangements for future payments. If you are NOT approved, your check will be returned to you.

NOTE: AccessWV does NOT accept third party checks for payment of premiums. Your premium must be paid by your own personal check or that of a spouse, a parent (in the case of a minor child) or an adult child. You may also pay by money order. A third party check will not be accepted, and your application will be returned**.**

Premium Payment: _____
Amount paid

ATTACH FIRST MONTH'S PAYMENT HERE

11. Affidavit Related to Premium Payment

I certify that neither my employer nor my spouse's employer is paying for my AccessWV premiums. No employer will be reimbursing me for premiums which I pay to AccessWV. I certify that no health care provider is paying for my AccessWV premiums. No health care provider will be reimbursing me for premiums which I pay to AccessWV. I understand that if either of the above statements is false, AccessWV may cancel any health insurance provided to me as if it had never been in effect and take any other action allowable to it by law.

_____ _____
Signature Date Signed

12. Future Method of Premium Payment

- ☐ I will pay directly on a monthly basis.
- ☐ I wish to arrange for automatic payment to be deducted directly from my bank account on a monthly basis. ***(Please complete Authorization on page 8 (back page) of this Application.).***

13. Affirmation of Pre-Existing Conditions

Please complete the following regarding any medical condition experienced in the last six months for all persons (applicant and dependents) listed on this application. Please see examples below. **Add extra pages as needed.**

Name	Medical Condition	Treating Physician	Prescription (s), if any
Jane Doe	High Cholesterol	Dr. Steve Jones	Lipitor
John Doe	Diabetes	Dr. Jacob Webster	Glipizide

Name	Medical Condition	Treating Physician	Prescription (s)

14. Affirmations and Understandings

I understand that I am applying to AccessWV offered by the Offices of the Insurance Commissioner, an agency of the State of West Virginia, for an individual policy of hospital, medical, surgical, and prescription insurance. I also understand that my coverage will become effective on the first day of the month following approval and acceptance of the application by AccessWV. I understand that I will be responsible for paying premiums from my effective date forward. I affirm that the answers on this application are complete and correct. I understand that, if convicted of perjury by providing inaccurate or incomplete information, I may be sentenced to not less than one year and no more that 10 years in jail.

1. Under penalty of perjury, I certify that I am a resident of the State of West Virginia and that I will continue to be legally domiciled and physically present in the State of West Virginia for the foreseeable future. I further certify that the residence listed as the Street Address is my permanent residence. I understand that if I falsely claim to be a resident of the State, I may be charged with committing perjury.

   I also understand that this statement will be relied upon in connection with future renewals of the insurance policy for which I am applying and the payment medical and pharmaceutical claims, and that it is my responsibility to inform AccessWV when I cease to be a West Virginia resident and that I will be subject to the penalties listed above if I fail to do so.

   I understand that I will be asked to file an updated certification of residency with AccessWV on at least an annual basis and to provide evidence of my residency. I will cooperate with this request when asked to do so.

   _____ Initial here showing you have read and understand the three paragraphs above.

2. Pre-existing conditions will not be covered until the AccessWV policy has been in effect for six months unless the pre-existing condition limitation period is waived. A pre-existing condition is a condition for which medical advice, care or treatment was recommended or received during the six-month period immediately preceding the AccessWV effective date of coverage. An existing pregnancy is considered a pre-existing condition.

   _____ Initial here showing you have read and understand the above paragraph.

3. If this application contains material misstatements or omissions, generally, and specifically related to **12. Affirmation of Pre-Existing Conditions**, AccessWV may do any or all of the following within two years from the date the policy was issued: a) cancel the agreement as though it had never been effective and refund premiums, less any claims paid; b) deny benefits under the pre-existing condition exclusion period; or c) take any other action available to it by law. This time limit does not apply to fraudulent misstatements. This application is part of any policy issued by AccessWV, in compliance with West Virginia insurance regulations.

   _____ Initial here showing you have read and understand the above paragraph.

4. Through my signature on this application I consent to disclosure to AccessWV of health insurance coverage, health insurance applications, Medicaid, Medicare and WVCHIP eligibility and medical record information about myself and my family members, listed on this application, if needed to: a) determine eligibility for coverage; b) preauthorize or process claims for benefits; c) perform case management (including concurrent review) or quality assurance reviews; or d) conduct an audit. AccessWV shall not release the medical record information it obtains to anyone else except as allowed by state and federal law.

   _____ Initial here showing you have read and understand the above paragraph.

   This consent takes effect on the date I sign this application and remains in effect for the lifetime of the AccessWV coverage or the duration of any claim including AccessWV claims against me, whichever is longer.

15. Certification and Signature

I certify that all information in this application is true and correct to the best of my knowledge.

Printed name of applicant:

_____

Signature of applicant:

_____ _____

Signature Date

For applicants under the age of 18, this form must be signed by the custodial parent or legal guardian of the applicant.

I am the ☐ custodial parent **OR** ☐ legal guardian of the applicant *(check one*). I certify that the above statements of the applicant are true and correct to the best of my knowledge.

_____ _____ _____

Printed Name Signature Date

16. Authorization Agreement for Monthly Automatic Bank Payment

Note: Please complete below if you wish to pay your AccessWV premiums by automatic bank payment. If you plan to pay directly each month by check or money order, you do NOT have to complete this page.

Name of Applicant or Policyholder: _____

Social Security Number: _____

Telephone Number: _____

I [or we if a joint account] authorize AccessWV to charge my [our] checking account for monthly insurance premiums. I [we] authorize the financial institution named below to honor and pay these monthly charges. This authority is to remain in effect until revoked by me [us] in writing, and until you actually receive such notice. I [we] agree that you shall be fully protected in honoring any such check/draft. I [we] understand that in order to cancel these automatic deductions, I [we] must provide written notice to AccessWV no less than 15 days before the next scheduled automatic deduction.

YOU MUST ATTACH A VOIDED CHECK WITH THIS AUTHORIZATION AGREEMENT TO BE USED BY THE BANK TO SET UP THE AUTOMATIC PAYMENT

Authorized Signature: _____

Account Number: _____

Financial Institution: _____

Note: If this form is not completed and signed, you will need to pay directly on a monthly basis. You must pay the premium due each month directly by check or money order until your bank processes this authorization or your coverage will be affected.

Attach Voided Check Here
For Automatic Payment